DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To: Pharmacists
Managed Care Plans
Regional Administrators
CSO Administrators

Memorandum No. **00-54 MAA**
Issued: July 1, 2000

For further information, call:
1-800-562-6188

From: James C. Wilson, Assistant Secretary
Medical Assistance Administration

Subject: **Change in Pharmacist Billing of Crossover Claims**

Effective August 1, 2000, the Medical Assistance Administration (MAA) will require pharmacists to use the appropriate HCPCS* code when billing MAA for drugs dispensed to dual-eligible clients, instead of MAA's state-unique code 0101E.

Instructions for completing field 24d on the HCFA-1500 claim form have been updated to reflect this change. Attached are replacement pages for Section I of your Prescription Drug Program Billing Instructions, dated December 1998.

* Health Care Financing Administration's Common Procedure Coding System

Medicare Part B/Medicaid Crossover HCFA-1500 Claim Form

Federal law requires a claim "paid" by Medicare to be submitted to Medicaid within six (6) months of the Medicare statement date.

When the words, "This information is being sent to either a private insurer or Medicaid fiscal agent," appear on your Medicare Remittance Notice, it means that your claim has been forwarded to MAA or a private insurer for deductible and/or coinsurance processing.

The HCFA-1500 claim form, used for Medicare/Medicaid Benefits Coordination, cannot be billed through the Point of Sale (POS) system.

If you have received a payment from Medicare, but it does not appear on your MAA Remittance and Status Report (RA) within 45 days from Medicare's statement date, you should bill MAA directly.

The Medicare/Medicaid billing form (HCFA-1500) must be submitted to MAA, Claims Processing Office:

Division of Program Support
PO Box 9247
Olympia WA 98507-9247

General Instructions

- Use an original, red and white HCFA-1500 (U2) (12-90) claim form.
- Enter only one (1) procedure code per detail line (fields 24A-24K). If you need to bill more than six (6) lines per claim, please complete an additional HCFA-1500 claim form.
- All information must be centered within the space allowed.
- Use upper case (capital letters) for all alpha characters.
- Do not write, print, or staple any attachments in the bar area at the top of the HCFA-1500 claim form.
- Attach complete, legible Medicare EOMB or claim will be denied.

FIELD DESCRIPTION

1a. **Insured's I.D. No.**: Required. Enter the Patient Identification Code (PIC) - an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the Medical Assistance IDentification (MAID) card. This information consists of the client's:

a) First and middle initials (a dash [-] *must* be used if the middle initial is not available).
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c) First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
d) An alpha or numeric character (tiebreaker).

For example:

1. Mary C. Johnson's PIC looks like this: MC010633JOHNSB.
2. John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100226LEE B.

Note: The MAID card is your proof of eligibility.

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the MAA client. **Sex**: Check **M** (male) or **F** (female).

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: Required. Enter the address of the Medicaid client who has received the services you are billing for (the person whose name is in *field 2*).

9. **Other Insured's Name**: Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.
9b. Enter the other insured's date of birth.
9c. Enter the other insured's employer's name or school name.
9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, or private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, Medicare, Indian Health, PCCM, Healthy Options, PCOP, etc., are inappropriate entries for this field.

10. **Is Patient's Condition Related To**: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24.* ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: Primary insurance. When applicable. This information applies to the insured person listed in *field 4.* Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and MAA pays as payor of last resort.

11a. **Insured's Date of Birth**: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3.*

11b. **Employer's Name or School Name**: Primary insurance. When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name**: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. **If 11d is left blank, the claim may be processed and denied in error.**

19. **Reserved For Local Use - Required. When Medicare allows services, enter *XO* to indicate this is a crossover claim.**

22. **Medicaid Resubmission**: When applicable. If this billing is being resubmitted more than six (6) months from Medicare's paid date, enter the Internal Control Number (ICN) that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.) Also enter the three-digit denial Explanation of Benefits (EOB).

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

24a. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., August 4, 2000 = 080400). **Do not use slashes, dashes, or hypens to separate month, day or year (MMDDYY)**

24b. **Place of Service**: Required. Enter a **9**.

24c. **Type of Service**: Required. Enter a **9**.

24d. **Procedures, Services or Supplies CPT/HCPCS**: Required. Enter **appropriate HCPCS**.

Coinsurance and Deductible: Required. Enter the total combined and deductible for each service in the space to the right of the modifier on each detail line.

24e. **Diagnosis Code**: Required. Enter appropriate diagnosis code for condition or use **V98.0.**

24f. **$ Charges**: Required. Enter the amount you billed Medicare for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax.

24g. **Days Or Units**: Required. Enter the appropriate units.

24k. **Reserved for Local Use**: Required. Use this field to show Medicare's allowed charges. Enter the Medicare's allowed charge on each detail line of the claim (see sample).

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, for example, a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.

27. **Accept Assignment**: Required. Check **yes.**

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: Required. Enter the Medicare Deductible here. Enter the amount as shown on Medicare's Remittance Notice and Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA-1500 claim forms (see field 24) and calculate the deductible based on the lines on each form. **Do not include coinsurance here.**

30. **Balance Due**: Required. Enter the Medicare Total Payment. Enter the amount as shown on Medicare's Remittance Notice or Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA claim forms (see field 24) and calculate the Medicare payment based on the lines on each form. **Do not include coinsurance here.**

32. **Name and Address of Facility Where Services Are Rendered**: Required. Enter Medicare Statement

Date ***and*** any Third-Party Liability Dollar Amount (e.g., auto, employee-sponsored, supplemental insurance) here, if any. If there is insurance payment on the claim, you must also attach the insurance Explanation of Benefits (EOB). **Do not include coinsurance here.**

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Phone #**: Required. Enter the pharmacy's *Name, Address,* and *Phone #* on all claim forms. Enter your seven-digit pharmacy provider number (which begins with six [6] here. **Do not use your NABP number for Medicare/Medicaid crossover claims.**

Sample HCFA-1500 Claim Form